Fields of Opportunities

STATE OF IOWA

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

IOWA DENTAL BOARD
CONSTANCE L. PRICE, EXECUTIVE DIRECTOR

INSTRUCTIONS FOR COMPLETING APPLICATION FOR DEEP SEDATION/GENERAL ANESTHESIA SEDATION PERMIT

Enclosed is an application for a permit to administer deep sedation/general anesthesia in the state of Iowa. When completing this application, please be advised of the following.

- Dentists licensed in the state of Iowa cannot administer deep sedation/general anesthesia or conscious sedation in the practice of dentistry unless a separate permit has been obtained from the Iowa Dental Board.
- **Conscious sedation** is defined in Board rules as "a depressed level of consciousness produced by the administration of pharmacologic substances, that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command." A conscious sedation permit is required to administer conscious sedation in Iowa. [650 IAC 29.1(153)]
- **Deep sedation/general anesthesia** is defined in Board rules as "a controlled state of unconsciousness, produced by a pharmacologic agent, accompanied by a partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command." A deep sedation/general anesthesia permit is required to administer deep sedation/general anesthesia in Iowa. A deep sedation permit also allows the permit holder to administer conscious sedation. [650 IAC 29.1(153)]
- Each facility in which an applicant plans to provide sedation is subject to an on-site evaluation prior to issuance of a permit. The actual costs associated with the on-site evaluation of the facility are the responsibility of the applicant. The cost to the licensee shall not exceed $500 per facility.
- Following review of a completed application and all required credentials by the Anesthesia Credentials Committee, a provisional permit may be issued pending final Board approval. A provisional permit may only be granted if the applicant will be practicing at a facility that has been inspected and approved by the Board.
- Based on its evaluation of credentials, facilities, equipment, personnel, and procedures, the Board may place restrictions on the permit.
- Once issued, a permit must be renewed biennially at the time of license renewal. Permit holders are required to maintain current ACLS certification and document six hours of continuing education in the area of sedation for each renewal.
- **Failure to answer all questions completely or accurately, and/or omission or falsification of material facts may be cause for denial of your application or disciplinary action.**
- All or part of the information provided on the application form may be considered a public record under Iowa Code chapter 22 and Iowa Administrative Code 650—Chapter 6.
- The application fee is non-refundable.

To assist you in completing the application, please utilize the following checklist and be sure that you have responded to each item.

☐ Type or legibly print the application.

☐ Complete each question on the application. If not applicable, answer N/A.

☐ Include a notarized copy of your marriage certificate or divorce decree if the name on your application is different than the name on your license or other documents.

☐ Include evidence of possessing a valid, current certificate in Advanced Cardiac Life Support (ACLS) by copying the front and back of your card.

☐ In section 3, basis for application, you must have completed part two of the 2003 ADA guidelines AND one of the following: formal training in airway management; or a minimum of one year of advanced training in anesthesiology and related academic subjects beyond the undergraduate dental school level in a training program approved by the board; or be a diplomate of the American Board of Oral and Maxillofacial Surgery or board eligible; or be a member of the American Association of Oral and Maxillofacial Surgeons; or be a Fellow of the American Dental Society of Anesthesiology.

☐ Attach proof of having met the qualifications in section 3, such as a copy of your diplomate certificate issued by the American Board of Oral & Maxillofacial Surgery, a copy of the certificate issued by the American Association of Oral & Maxillofacial Surgeons, or a copy of the fellow certificate issued by the American Dental Society of Anesthesiology.

☐ Complete the top portion of the verification of postgraduate residency program and mail the form to your postgraduate training program to complete. The program should mail the form directly to the Board office.

☐ Attach a copy of your certificate of completion for each postgraduate residency program.

☐ Copy and complete page 3 of the application for each facility in which you plan to provide sedation. Each facility is subject to inspection.

☐ Prior to completing the questions in section 9, read the following definitions.

"Ability to practice dentistry with reasonable skill and safety" means ALL of the following:

1. The cognitive capacity to make appropriate clinical diagnosis, exercise reasoned clinical judgments, and to learn and keep abreast of clinical developments;
2. The ability to communicate clinical judgments and information to patients and other health care providers; and
3. The capability to perform clinical tasks such as dental examinations and dental surgical procedures.

"Medical condition" means any physiological, mental, or psychological condition, impairment, or disorder, including drug addiction and alcoholism.

"Chemical substances" means alcohol, legal and illegal drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of chemical substances or medical conditions may have an ongoing impact on the ability to function and practice, or has adversely affected the ability to function and practice within the past two (2) years.

"Improper use of drugs or other chemical substances" means ANY of the following:

1. The use of any controlled drug, legend drug, or other chemical substance for any purpose other than as directed by a licensed health care practitioner; and
2. The use of any substance, including but not limited to, petroleum products, adhesive products, nitrous oxide, and other chemical substances for mood enhancement.

"Illegal use of drugs or other chemical substances" means the manufacture, possession, distribution, or use of any drug or chemical substance prohibited by law.

☐ For each "Yes" answer in section 9, you must provide a separate, signed statement giving full details, including date(s), location(s), action(s), organization(s) or parties involved, and specific reason(s).

☐ If you have a license, permit, or registration to perform sedation in any other state, request verification of your permit from each state. Please note that some states may require a processing fee.

☐ The application must be notarized.

☐ Enclose the non-refundable application fee of $500, made payable to Iowa Dental Board.

IOWA DENTAL BOARD
400 S.W. 8th Street, Suite D, Des Moines, Iowa 50309-4687
Phone (515) 281-5157 Fax (515) 281-7969
http://www.dentalboard.iowa.gov

APPLICATION FOR DEEP SEDATION/GENERAL ANESTHESIA PERMIT

SECTION 1 – APPLICANT INFORMATION				
Instructions – Please read the accompanying instructions prior to completing this form. Answer each question. If not applicable, mark "N/A."				
Full Legal Name: (Last, First, Middle, Suffix)				
Other Names Used: (e.g. Maiden)	**Home E-mail:**		**Work E-mail:**	
Home Address:	**City:**	**State:**	**Zip:**	**Home Phone:**
License Number:	**Issue Date:**	**Expiration Date:**	**Type of Practice:**	

SECTION 2 – LOCATION(S) IN IOWA WHERE SEDATION SERVICES WILL BE PROVIDED				
Principal Office Address:	**City:**	**Zip:**	**Phone:**	**Office Hours/Days:**
Other Office Address:	**City:**	**Zip:**	**Phone:**	**Office Hours/Days:**
Other Office Address:	**City:**	**Zip:**	**Phone:**	**Office Hours/Days:**
Other Office Address:	**City:**	**Zip:**	**Phone:**	**Office Hours/Days:**
Other Office Address:	**City:**	**Zip:**	**Phone:**	**Office Hours/Days:**

SECTION 3 – BASIS FOR APPLICATION		
Check each box to indicate the type of training you have completed & attach proof, such as a copy of your diplomate certificate.	**Check all that apply.**	**DATE(S):**
American Dental Association Council on Dental Education Guidelines (2003) Part 2		
You must have training in ADA Part 2 AND one of the following: **Formal training in airway management; OR**		
One year of advanced training in anesthesiology in board-approved program; OR		
Diplomate of American Board of Oral and Maxillofacial Surgery; OR		
Eligible for exam by American Board of Oral & Maxillofacial Surgery; OR		
Member of American Association of Oral & Maxillofacial Surgeons; OR		
Fellow of American Dental Society of Anesthesiology.		

SECTION 4 – ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION	
Name of Course:	**Location:**
Date of Course:	**Date Certification Expires:**

Office Use				
	Lic. #	Sent to ACC:		Fee
	Permit #	Approved by ACC:	State Ver.:	ACLS
	Issue Date:	Temp #	Inspection	Res. Ver Form
	Brd Approved:	T. Issue Date:	Diplomate Cert	Res Cert

Name of Applicant _____

SECTION 5 – DENTAL EDUCATION, TRAINING & EXPERIENCE

Name of Dental School:	From (Mo/Yr):	To (Mo/Yr):
City, State:	Degree Received:	

POST-GRADUATE TRAINING. Attach a copy of your certificate of completion for each postgraduate program you have completed.

Name of Training Program:	Address:	City:	State:
Phone:	Specialty:	From (Mo/Yr):	To (Mo/Yr):

Type of Training: ☐ Intern ☐ Resident ☐ Fellow ☐ Other (Be Specific):

Name of Training Program:	Address:	City:	State:
Phone:	Specialty:	From (Mo/Yr):	To (Mo/Yr):

Type of Training: ☐ Intern ☐ Resident ☐ Fellow ☐ Other (Be Specific):

CHRONOLOGY OF ACTIVITIES

Provide a chronological listing of all dental and non-dental activities from the date of your graduation from dental school to the present date, with no more than a three (3) month gap in time. Include months, years, location (city & state), and type of practice. Attach additional sheets of paper, if necessary, labeled with your name and signed by you.

Activity & Location	From (Mo/Yr):	To (Mo/Yr):

SECTION 6 – DEEP SEDATION/GENERAL ANESTHESIA EXPERIENCE

☐ YES ☐ NO **A. Do you have a license, permit, or registration to perform sedation in any other state?**

If yes, specify state(s) and permit number(s):_____

☐ YES ☐ NO **B. Do you consider yourself engaged in the use of deep sedation/general anesthesia in your professional practice?**

☐ YES ☐ NO **C. Have you ever had any patient mortality or other incident that resulted in the temporary or permanent physical or mental injury requiring hospitalization of the patient during, or as a result of, your use of antianxiety premedication, nitrous oxide inhalation analgesia, conscious sedation or deep sedation/general anesthesia?**

☐ YES ☐ NO **D. Do you plan to use deep sedation/general anesthesia in pediatric patients?**

☐ YES ☐ NO **E. Do you plan to use deep sedation/general anesthesia in medically compromised patients?**

☐ YES ☐ NO **F. Do you plan to engage in enteral conscious sedation?**

☐ YES ☐ NO **G. Do you plan to engage in parenteral conscious sedation?**

What major drugs and anesthetic techniques do you utilize or plan to utilize for sedation purposes? Provide details (IV, inhalation, etc.) and attach a separate sheet if necessary.

Name of Applicant ____ Facility Address_________________________________

SECTION 7 – AUXILIARY PERSONNEL

A dentist administering conscious sedation in Iowa must document and ensure that all auxiliary personnel have certification in basic life support (BLS) and are capable of administering basic life support. Please list below the name(s), license/registration number, and BLS certification status of all auxiliary personnel.

Name:	**License/ Registration #:**	**BLS Certification Date:**	**Date BLS Certification Expires:**
Name:	**License/ Registration #:**	**BLS Certification Date:**	**Date BLS Certification Expires:**
Name:	**License/ Registration #:**	**BLS Certification Date:**	**Date BLS Certification Expires:**
Name:	**License/ Registration #:**	**BLS Certification Date:**	**Date BLS Certification Expires:**
Name:	**License/ Registration #:**	**BLS Certification Date:**	**Date BLS Certification Expires:**
Name:	**License/ Registration #:**	**BLS Certification Date:**	**Date BLS Certification Expires:**
Name:	**License/ Registration #:**	**BLS Certification Date:**	**Date BLS Certification Expires:**
Name:	**License/ Registration #:**	**BLS Certification Date:**	**Date BLS Certification Expires:**

SECTION 8 – FACILITIES & EQUIPMENT

Each facility in which you perform sedation must be properly equipped. Copy this page and complete for each facility. You may apply for a waiver of any of these provisions. The Board may grant the waiver if it determines there is a reasonable basis for the waiver.

YES	NO	Is your dental office properly maintained and equipped with the following:
☐	☐	**1. An operating room large enough to adequately accommodate the patient on a table or in an operating chair and permit an operating team consisting of at least three individuals to move freely about the patient?**
☐	☐	**2. An operating table or chair that permits the patient to be positioned so the operating team can maintain the airway, quickly alter the patient position in an emergency, and provide a firm platform for the management of cardiopulmonary resuscitation?**
☐	☐	**3. A lighting system that is adequate to permit evaluation of the patient's skin and mucosal color and a backup lighting system that is battery powered and of sufficient intensity to permit completion of any operation underway at the time of general power failure?**
☐	☐	**4. Suction equipment that permits aspiration of the oral and pharyngeal cavities and a backup suction device?**
☐	☐	**5. An oxygen delivery system with adequate full face masks and appropriate connectors that is capable of delivering oxygen to the patient under positive pressure, together with an adequate backup system?**
☐	☐	**6. A recovery area that has available oxygen, adequate lighting, suction, and electrical outlets? (The recovery area can be the operating room.)**
☐	☐	**7. Is the patient able to be observed by a member of the staff at all times during the recovery period?**
☐	☐	**8. Anesthesia or analgesia systems coded to prevent accidental administration of the wrong gas and equipped with a fail safe mechanism?**
☐	☐	**9. EKG monitor?**
☐	☐	**10. Laryngoscope and blades?**
☐	☐	**11. Endotracheal tubes?**
☐	☐	**12. Magill forceps?**
☐	☐	**13. Oral airways?**
☐	☐	**14. Stethoscope?**
☐	☐	**15. A blood pressure monitoring device?**
☐	☐	**16. A pulse oximeter?**
☐	☐	**17. Emergency drugs that are not expired?**
☐	☐	**18. A defibrillator (an automated defibrillator is recommended)?**
☐	☐	**19. Do you employ volatile liquid anesthetics and a vaporizer (i.e. Halothane, Enflurane, Isoflurane)?**
________		**20. In the space provided, list the number of nitrous oxide inhalation analgesia units in your facility.**

SECTION 9 – If you answer Yes to any of the questions below, attach a full explanation. Read the instructions for important definitions.

	YES	NO
1. Do you currently have a medical condition that in any way impairs or limits your ability to practice dentistry with reasonable skill and safety?	☐	☐
2. Are you currently engaged in the illegal or improper use of drugs or other chemical substances?	☐	☐
3. Do you currently use alcohol, drugs, or other chemical substances that would in any way impair or limit your ability to practice dentistry with reasonable skill and safety?	☐	☐
4. If YES to any of the above, are you receiving ongoing treatment or participation in a monitoring program that reduces or eliminates the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances?	☐	☐
5. Have you ever been requested to repeat a portion of any professional training program/school?	☐	☐
6. Have you ever received a warning, reprimand, or been placed on probation during a professional training program/school?	☐	☐
7. Have you ever voluntarily surrendered a license or permit issued to you by any professional licensing agency?	☐	☐
7a. If yes, was a license disciplinary action pending against you, or were you under investigation by a licensing agency at that time the voluntary surrender of license was tendered?	☐	☐
8. Aside from ordinary initial requirements of proctorship, have your clinical activities ever been limited, suspended, revoked, not renewed, voluntarily relinquished, or subject to other disciplinary or probationary conditions?	☐	☐
9. Has any jurisdiction of the United States or other nation ever limited, restricted, warned, censured, placed on probation, suspended, or revoked a license or permit you held?	☐	☐
10. Have you ever been notified of any charges filed against you by a licensing or disciplinary agency of any jurisdiction of the U.S. or other nation?	☐	☐
11. Have you ever been denied a Drug Enforcement Administration (DEA) or state controlled substance registration certificate or has your controlled substance registration ever been placed on probation, suspended, voluntarily surrendered or revoked?	☐	☐

SECTION 10 – AFFIDAVIT OF APPLICANT

STATE:	**COUNTY:**

I, the below named applicant, hereby declare under penalty of perjury that I am the person described and identified in this application and that my answers and all statements made by me on this application and accompanying attachments are true and correct. Should I furnish any false information, or have substantial omission, I hereby agree that such act shall constitute cause for denial, suspension, or revocation of my license or permit to provide deep sedation/general anesthesia. I also declare that if I did not personally complete the foregoing application that I have fully read and confirmed each question and accompanying answer, and take full responsibility for all answers contained in this application.

I understand that I have no legal authority to administer deep sedation/general anesthesia until a permit has been granted. I understand that my facility is subject to an on-site evaluation prior to the issuance of a permit and by submitting an application for a deep sedation/general anesthesia permit, I hereby consent to such an evaluation. In addition, I understand that I may be subject to a professional evaluation as part of the application process. The professional evaluation shall be conducted by the Anesthesia Credentials Committee and include, at a minimum, evaluation of my knowledge of case management and airway management.

I certify that I am trained and capable of administering Advanced Cardiac Life Support and that I employ sufficient auxiliary personnel to assist in monitoring a patient under deep sedation/general anesthesia. Such personnel are trained in and capable of monitoring vital signs, assisting in emergency procedures, and administering basic life support. I understand that a dentist performing a procedure for which deep sedation/general anesthesia is being employed shall not administer the general anesthetic and monitor the patient without the presence and assistance of at least two qualified auxiliary personnel.

I am aware that pursuant to Iowa Administrative Code 650—29.9(153) I must report any adverse occurrences related to the use of deep sedation/general anesthesia, or conscious sedation.

I hereby authorize the release of any and all information and records the Board shall deem pertinent to the evaluation of this application, and shall supply to the Board such records and information as requested for evaluation of my qualifications for a permit to administer sedation in the state of Iowa.

I understand that based on evaluation of credentials, facilities, equipment, personnel, and procedures, the Board may place restrictions on the permit.

I further state that I have read the rules related to the use of conscious sedation, deep sedation/general anesthesia and nitrous oxide inhalation analgesia, as described in 650 Iowa Administrative Code Chapter 29. I hereby agree to abide by the laws and rules pertaining to the practice of dentistry and deep sedation/general anesthesia in the state of Iowa.

MUST BE SIGNED IN PRESENCE OF NOTARY ►	**SIGNATURE OF APPLICANT**	
NOTARY SEAL	**SUBSCRIBED AND SWORN BEFORE ME, THIS DAY OF , YEAR**	
	NOTARY PUBLIC SIGNATURE	
	NOTARY PUBLIC NAME (TYPED OR PRINTED)	**MY COMMISSION EXPIRES:**

IOWA DENTAL BOARD

400 S.W. 8th Street, Suite D, Des Moines, Iowa 50309-4687
Phone (515) 281-5157 Fax (515) 281-7969
http://www.dentalboard.iowa.gov

PLEASE TYPE OR PRINT LEGIBLY IN INK.

VERIFICATION OF POSTGRADUATE RESIDENCY PROGRAM

SECTION 1 – APPLICANT INFORMATION

Instructions – Complete Section 1 and mail this form to the Postgraduate Program Director for verification of your postgraduate training.

NAME (First, Middle, Last, Suffix, Former/Maiden):			
MAILING ADDRESS:			
CITY:	**STATE:**	**ZIP CODE:**	**PHONE:**

To obtain a permit to administer deep sedation/general anesthesia in Iowa, the Iowa Dental Board requires that the applicant submit evidence of having completed an approved postgraduate training program or other formal training program approved by the Board. The applicant's signature below authorizes the release of any information, favorable or otherwise, directly to the Iowa Dental Board at the address above.

APPLICANT'S SIGNATURE:	**DATE:**

SECTION 2 – TO BE COMPLETED BY POSTGRADUATE PROGRAM DIRECTOR

NAME OF POSTGRADUATE PROGRAM DIRECTOR:

THIS POSTGRADUATE PROGRAM IS APPROVED OR ACCREDITED TO TEACH POSTGRADUATE DENTAL OR MEDICAL EDUCATION BY ONE OF THE FOLLOWING:

- ☐ **American Dental Association;**
- ☐ **Accreditation Council for Graduate Medical Education of the American Medical Association (AMA); or**
- ☐ **Education Committee of the American Osteopathic Association (AOA).**

NAME AND LOCATION OF POSTGRADUATE PROGRAM:			**PHONE:**
DATES APPLICANT PARTICIPATED IN PROGRAM ►	**FROM (MO/YR):**	**TO (MO/YR):**	**DATE PROGRAM COMPLETED:**

☐ **YES** ☐ **NO 1. DID THE APPLICANT SATISFACTORILY COMPLETE THE ABOVE POSTGRADUATE TRAINING PROGRAM?** If no, please explain.

☐ **YES** ☐ **NO 2. DID THE APPLICANT EVER RECEIVE A WARNING, REPRIMAND, OR WAS THE APPLICANT PLACED ON PROBATION DURING THE TRAINING PROGRAM?** If yes, please explain.

☐ **YES** ☐ **NO 3. WAS THE APPLICANT EVER REQUESTED TO REPEAT A PORTION OF THE TRAINING PROGRAM?** If yes, please explain.

☐ **YES** ☐ **NO 4. DOES THE PROGRAM COVER PART 2 OF THE 2003 AMERICAN DENTAL ASSOCIATION GUIDELINES FOR TEACHING THE COMPREHENSIVE CONTROL OF ANXIETY AND PAIN AT THE ADVANCED EDUCATION LEVEL?** If no, please explain.

☐ **YES** ☐ **NO 4. DOES THE PROGRAM INCLUDE ADDITIONAL TRAINING IN MANAGING PEDIATRIC OR MEDICALLY COMPROMISED PATIENTS?** If yes, please provide details.

I further certify that the above named applicant has demonstrated competency in airway management and deep sedation/general anesthesia.

PROGRAM DIRECTOR SIGNATURE:	**DATE:**